FOR OHF USE

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042549

Facility Name: RIVER PARK HEALTHCARE CENTER

Address: 2545 24th ST (Number) ROCK ISLAND (City) 61201 (Zip Code)

County: ROCK ISLAND

Telephone Number: (847) 647-1717 **Fax #** (847) 647-0222

IDPA ID Number: 36-4127168

Date of Initial License for Current Owners: 03/06/97

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHERWIN I. RAY
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	177	Skilled (SNF)	177	64,782	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	177	TOTALS	177	64,782	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,806		5,098	6,904	8
9	SNF/PED					9
10	ICF	38,421	5,896		44,317	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,227	5,896	5,098	51,221	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.07%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/06/97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/06/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 5,098

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	168,231	18,665	13,776	200,672		200,672	(1,135)	199,537			1
2	Food Purchase		206,648		206,648	(13,725)	192,923	(879)	192,044			2
3	Housekeeping	137,808	28,666		166,474		166,474		166,474			3
4	Laundry	64,950	12,112		77,062		77,062		77,062			4
5	Heat and Other Utilities			135,958	135,958		135,958	709	136,667			5
6	Maintenance	50,862	44,540	31,522	126,924		126,924	10,643	137,567			6
7	Other (specify):*			8,418	8,418		8,418	372	8,790			7
8	**TOTAL General Services**	421,851	310,631	189,674	922,156	(13,725)	908,431	9,710	918,141			8
	B. Health Care and Programs											
9	Medical Director			16,800	16,800		16,800		16,800			9
10	Nursing and Medical Records	1,498,103	90,001	276,551	1,864,655		1,864,655	(247,714)	1,616,941			10
10a	Therapy	116,398	5,007	65,339	186,744		186,744	(53,566)	133,178			10a
11	Activities	81,724	5,930	59	87,713		87,713		87,713			11
12	Social Services	77,370		2,115	79,485		79,485		79,485			12
13	Nurse Aide Training											13
14	Program Transportation			42	42		42		42			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,773,595	100,938	360,906	2,235,439		2,235,439	(301,280)	1,934,159			16
	C. General Administration											
17	Administrative	109,664		158,000	267,664		267,664	(52,848)	214,816			17
18	Directors Fees											18
19	Professional Services			353,712	353,712		353,712	(219,158)	134,554			19
20	Dues, Fees, Subscriptions & Promotions			17,696	17,696		17,696	(6,537)	11,159			20
21	Clerical & General Office Expenses	108,147	14,416	145,912	268,475		268,475	(28,044)	240,431			21
22	Employee Benefits & Payroll Taxes			329,631	329,631	13,725	343,356		343,356			22
23	Inservice Training & Education			2,094	2,094		2,094	1,312	3,406			23
24	Travel and Seminar			1,395	1,395		1,395	432	1,827			24
25	Other Admin. Staff Transportation			4,549	4,549		4,549	4,359	8,908			25
26	Insurance-Prop.Liab.Malpractice			182,711	182,711		182,711	2,743	185,454			26
27	Other (specify):*							48,357	48,357			27
28	**TOTAL General Administration**	217,811	14,416	1,195,700	1,427,927	13,725	1,441,652	(249,384)	1,192,268			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,413,257	425,985	1,746,280	4,585,522		4,585,522	(540,954)	4,044,568			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: RIVER PARK HEALTHCARE CENTER #0042549 **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	13,322	
	REPAIRS & MAINTENANCE		454	
			0	13,776
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		24,083	
	ELECTRICITY		72,281	
	WATER		24,215	
	CABLE TV - LOBBY		15,379	
			0	135,958
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		0	
	PAINTING & DECORATING		875	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		8,559	
	ELEVATOR MAINTENANCE & REPAIR		10,995	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		0	
	FIRE SERVICE		11,093	
			0	
			0	
			0	31,522
7	**OTHER**			
	SCAVENGER		8,418	
	SECURITY SERVICE		0	8,418
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	16,800	16,800

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	0	
	LABORATORY & XRAY EXPENSE		1,151	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	400	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS		0	
	PSYCHIATRIC	XVIII B 47-2	50,000	
	RN CONSULTANT	XVIII B 38-2	0	
	MEDICARE & PUBLIC AID CONSULTANT	XVIII B 48-2	225,000	
			0	276,551
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		5,564	
	SPEECH THERAPY SERVICES		909	
	OCCUPATIONAL THERAPY SERVICES		3,546	
	THERAPY CONTRACT SERVICES		40,920	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	7,200	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	7,200	
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	65,339
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	59	
			0	59
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,115	
			0	2,115
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER **#0042549** **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		42	42
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	158,000	158,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	24,967	
	ADMINISTRATIVE CONSULTANTS	XIX C	210,000	
	PROFESSIONAL FEES	XIX C	118,745	
			0	353,712
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	8,769	
	EMPLOYEE WANT ADS	XIX F	6,444	
	CONTRIBUTIONS	VI 20 XIX F	50	
	DUES & SUBSCRIPTIONS	XIX F	122	
	LICENSES & PERMITS	XIX F	1,283	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	485	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	385	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	50	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	108	17,696
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		6,242	
	OUTSIDE CLERICAL SERVICES		106,200	
	PENALTIES / OVERDRAFT CHARGES	VI 18	13,709	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		166	
	TELEPHONE		17,746	
	MESSENGER SERVICE		1,849	
			0	145,912

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	181,183	
	UNEMPLOYMENT COMPENSATION	XIX D	34,475	
	WORKERS COMPENSATION INSURANCI	XIX D	64,383	
	HOSPITALIZATION INSURANCE	XIX D	46,120	
	EMPLOYEE BENEFITS - OTHER	XIX D	3,470	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	329,631
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,094	2,094
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	1,395	
			0	
			0	1,395
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		4,549	4,549
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		182,711	182,711
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 1,746,280

RIVER PARK HEALTHCARE CENTER
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	206,648	PATIENT MEALS	153663
LESS SALES TAX	(879)	ADD EMPLOYEE MEALS	10980
NET FOOD	205,769	TOTAL MEALS/YEAR	164643
TOTAL PATIENT CENSUS	51,221	NET FOOD	205769
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	164643
TOTAL PATIENT MEALS	153663	COST PER MEAL	1.25
		TIME EMPLOYEE MEALS	10980
ADD # EMPLOYEE MEALS/DAY	30		
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	13725
TOTAL EMPLOYEE MEALS	10980		

RIVER PARK HEALTHCARE CENTER INC
EDUCATION & SEMINAR
12/31/04 **ACCT #18180**

DATE	INV	SPONSOR OF SEMINAR	PURPOSE OF SEMINAR	PERSONNEL ATTENDING	LOC	COST OF SEMINAR
1.04	X	DMA	PUBLICATIONS	KATHY MAYER		48.15
1.04	X	ICLTC	PAIN MANAGEMENT: PUTTIGN THEORY INTO	CHRIS WELCH	IL	95.00
			PRACTICE	DAWN MAY	IL	95.00
				CINDY WALLER	IL	95.00
				ROMY MACASAET	IL	95.00
2.04	X	ICLTC	NEW ENFORCEMENT OF SUBPART S	CHRIS WELCH	IL	95.00
				ROMY MACASAET	IL	95.00
3.04	X	ICLTC	THE WITNESS STAND: EVERY NURSE'S NIGHTMARE	CHRIS WELCH	IL	95.00
3.04	X	IL HEALTHCARE ASSOCIATION	ADLs, PAIN MANAGEMENT, SKIN CARE	DAWN MAY	IL	165.00
3.04	X	CROSS COUNTRY UNIVERSITY	ACTIVITY PROGRAMMING IN LONG-TERM CARE	BARB MARTENS	IL	159.00
4.04	X	IL DEPT. OF PUBLIC HEALTH	RENEWEL OF FSSMC CERTIFICATE	DARRELL HARRIS	IL	35.00
5.04	X	CHRIS WELCH - PETTY CASH	HOTEL ROOM/RESTURANT	CHRIS WELCH	IL	129.86
5.04	X	ICLTC	MANAGING CUSTOMER EXPECTATIONS THROUGH	CHRIS WELCH	IL	95.00
			ADMISSION AND BEYOND			
6.04	X	ROBERT YOUNG CENTER	GENERATIONS: FACING THE CHALLENGES	CHRIS WELCH	IL	40.00
				DAWN MAY	IL	40.00
6.04	X	ICLTC	G & P3: ADL BASE AND RESTORATIVES	ROMY MACASAET	IL	145.00
				CHRIS WELCH	IL	145.00
6.04	X	WORLD POINT ECC	HEARTSAVER AED INSTRUCTORS TOOLKIT + ACCES.	DAWN MAY	IL	390.90
8.04	X	DMA	PUBLICATIONS			26.40
12.04	X	DMA EDUCATION DEPT.	PROFESSIONAL PRACTICE STANDARDS: SANITATION	KATHY CLARK		10.00
TOTAL						2,094.31

RIVER PARK HEALTHCARE CENTER INC
EQUIPMENT RENTAL
12/31/04

VENDOR	DESCRIPTION	AMOUNT
ADVA-CARE	NURSING EQUIPMENT	$ 173
MEDICAL SPECIALTIES	NURSING EQUIPMENT	21,752
KREG THERAPEUTICS	NURSING EQUIPMENT	350
TRI-STATE SURGICAL	NURSING EQUIPMENT	3,392
RCS MANAGEMENT	NURSING EQUIPMENT	356
METRO MEDICAL	NURSING EQUIPMENT	154
FAMILY PRIDE	WASHER/DRYER	9,300
TOSHIBA AMERICA	COPIER	2,090
		37,567
CAREPLUS REHAB	EQUIPMENT LEASE	59,655
		97,222

RIVER PARK HEALTHCARE CENTER INC
PROFESSIONAL FEES
12/31/04

VENDOR	DESCRIPTION	AMOUNT
CARE PLUS	DATA PROCESSING	$ 13,200.00
ACHIEVE	DATA PROCESSING	3,996.78
E-HEALTH DATA	DATA PROCESSING	1,014.00
AMERICAN DATA	DATA PROCESSING	3,198.69
NATIONAL DATACARE	DATA PROCESSING	3,558.00
CARE PLUS	ADMINISTRATIVE CONSULTANT	210,000.00
KBKB	ACCOUNTING	32,450.00
BROOKS & TRINIDAD	LEGAL	91.75
MEYER MAGENCE	LEGAL	4,127.80
MARGARET GROENWALD	LEGAL	75,000.00
SACHNOFF & WEAVER	LEGAL	360.00
PERSONNEL PLANNER	UC CONSULTANT	915.00
P.K.BHOSALE		1,000.00
RICHARD PEELO	MEDICARE CONSULTANT	4,800.00
	TOTAL	353,712.02

RIVER PARK HEALTHCARE CENTER INC
TRANSPORTATION - STAFF
12/31/04

		G/L #18370	
	SEC'Y STATE	CHRIS WELCH PETTY CASH	TOTAL
JAN		364.01	364.01
FEB		393.10	393.10
MAR		716.00	716.00
APR		746.01	746.01
MAY		337.05	337.05
JUN	78.00	313.21	391.21
JUL		326.44	326.44
AUG		323.03	323.03
SEP		246.74	246.74
OCT		228.00	228.00
NOV		210.00	210.00
DEC		267.25	267.25
TOTAL	78.00	4,470.84	4,548.84

GASOLINE FOR FACILITY BANKING, MAINTENANCE, MARKETING, AND ACTIVITIES

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER #0042549 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			29,717	29,717		29,717	120,274	149,991			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,973	3,973		3,973	373,710	377,683			32
33	Real Estate Taxes			138,626	138,626		138,626		138,626			33
34	Rent-Facility & Grounds			445,958	445,958		445,958	(439,502)	6,456			34
35	Rent-Equipment & Vehicles			97,222	97,222		97,222	(52,651)	44,571			35
36	Other (specify):*											36
37	**TOTAL Ownership**			715,496	715,496		715,496	1,831	717,327			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		191,119	186,611	377,730		377,730	(156,081)	221,649			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			97,174	97,174		97,174		97,174			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		191,119	283,785	474,904		474,904	(156,081)	318,823			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,413,257	617,104	2,745,561	5,775,922		5,775,922	(695,204)	5,080,718			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,858)	30		9
10	Interest and Other Investment Income	(3,973)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(879)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(385)	20		17
18	Fines and Penalties	(13,709)	21		18
19	Entertainment				19
20	Contributions	(100)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(8,769)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(485)	20		28
29	Other-Attach Schedule	(14,395)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (49,553)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(645,651)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (645,651)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (695,204)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

RIVER PARK HEALTHCARE CENTER

ID# 0042549

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 3414	6	1
2	MARKETING SALARY	(17,809)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(14,395)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	(1,135)	0	0	0	0	0	0	0	0	0	(1,135)	1
2	Food Purchase	(879)	0	0	0	0	0	0	0	0	0	0	(879)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	709	0	0	0	0	0	0	0	0	0	709	5
6	Maintenance	3,414	7,229	0	0	0	0	0	0	0	0	0	10,643	6
7	Other (specify):*	0	0	372	0	0	0	0	0	0	0	0	372	7
8	**TOTAL General Services**	2,535	6,803	372	0	0	0	0	0	0	0	0	9,710	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(247,714)	0	0	0	0	0	0	0	0	0	(247,714)	10
10a	Therapy	0	3,604	(57,170)	0	0	0	0	0	0	0	0	(53,566)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(244,110)	(57,170)	0	0	0	0	0	0	0	0	(301,280)	16
	C. General Administration													
17	Administrative	0	(52,848)	0	0	0	0	0	0	0	0	0	(52,848)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(223,200)	4,042	0	0	0	0	0	0	0	0	(219,158)	19
20	Fees, Subscriptions & Promotions	(9,739)	0	3,202	0	0	0	0	0	0	0	0	(6,537)	20
21	Clerical & General Office Expenses	(31,518)	(106,200)	109,674	0	0	0	0	0	0	0	0	(28,044)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	1,312	0	0	0	0	0	0	0	0	1,312	23
24	Travel and Seminar	0	0	432	0	0	0	0	0	0	0	0	432	24
25	Other Admin. Staff Transportation	0	0	4,359	0	0	0	0	0	0	0	0	4,359	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,743	0	0	0	0	0	0	0	0	2,743	26
27	Other (specify):*	0	0	48,357	0	0	0	0	0	0	0	0	48,357	27
28	**TOTAL General Administration**	(41,257)	(382,248)	174,121	0	0	0	0	0	0	0	0	(249,384)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(38,722)	(619,555)	117,323	0	0	0	0	0	0	0	0	(540,954)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(6,858)	0	127,132	0	0	0	0	0	0	0	0	120,274	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,973)	0	377,683	0	0	0	0	0	0	0	0	373,710	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(439,502)	0	0	0	0	0	0	0	0	(439,502)	34
35	Rent-Equipment & Vehicles	0	0	(52,651)	0	0	0	0	0	0	0	0	(52,651)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(10,831)	0	12,662	0	0	0	0	0	0	0	0	1,831	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	(156,081)	0	0	0	0	0	0	0	0	(156,081)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	(156,081)	0	0	0	0	0	0	0	0	(156,081)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(49,553)	(619,555)	(26,096)	0	0	0	0	0	0	0	0	(695,204)	45

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT	SKOKIE	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
SEE ATTACHED SCHEDULES					SKOKIE	THERAPY
				RIVER PARK HEALTHCARE CENTER LLC		
					SKOKIE	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 126,000	CAREPLUS MGMT INC		$	$ (126,000)	1
2	V	19	ADMIN. CONSULTANT FEES	210,000	" "			(210,000)	2
3	V	19	DATA PROCESSING FEES	13,200	" "			(13,200)	3
4	V	21	CLERICAL FEES	106,200	" "			(106,200)	4
5	V	1	DIETARY CONSULTANT FEES	4,200	" "			(4,200)	5
6	V	10	M/C,PA,PSYCH FEES	275,000	" "			(275,000)	6
7	V	1	DIETARY SALARIES		" "		3,065	3,065	7
8	V	5	ELECTRICITY		" "		709	709	8
9	V	6	REPAIRS		" "		25	25	9
10	V	6	MAINTENANCE SALARIES		" "		7,204	7,204	10
11	V	10	NURSING		" "		27,286	27,286	11
12	V	10a	THERAPY SALARIES		" "		3,604	3,604	12
13	V	17	ADMIN SALARIES		" "		73,152	73,152	13
14	Total			$ 734,600			$ 115,045	$ * (619,555)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	CAREPLUS MGMT INC		$ 4,042	$ 4,042	15
16	V	20	DUES/LICENSES/WANT ADS		" "		3,202	3,202	16
17	V	21	OFFICE SALARIES/EXPENSES		" "		109,674	109,674	17
18	V	23	SEMINARS		" "		1,312	1,312	18
19	V	24	TRAVEL		" "		432	432	19
20	V	25	TRANSPORTATION		" "		4,359	4,359	20
21	V	26	INSURANCE		" "		2,743	2,743	21
22	V	27	EMPLOYEE BENEFITS		" "		48,357	48,357	22
23	V	30	SL DEPRECIATION		" "		10,525	10,525	23
24	V	32	INTEREST		" "		30,195	30,195	24
25	V	34	OFFICE RENT		" "		6,456	6,456	25
26	V	35	EQUIP RENT/AUTO LEASE		" "		7,004	7,004	26
27	V	7	SECURITY		" "		372	372	27
28	V								28
29	V	34	RENT	445,958	RIVER PARK HEALTHCARE CENTER LLC			(445,958)	29
30	V	30	SL DEPRECIATION		" "		116,607	116,607	30
31	V	32	INTEREST		" "		347,488	347,488	31
32	V								32
33	V								33
34	V	10a	THERAPY SERVICES	65,338	CAREPLUS REHABILITATIVE SERVICES		8,168	(57,170)	34
35	V	39	ANCILLARY THERAPY	186,611	" "		30,530	(156,081)	35
36	V	35	EQUIPMENT RENT EXPENSE	59,655	" "			(59,655)	36
37	V				" "				37
38	V				" "				38
39	Total			$ 757,562			$ 731,466	$ * (26,096)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								$		1
2	SHERWIN RAY	PRESIDENT	ADMIN/FINANCE	32.02	SEE ATTACHED	5.4	9.06	SALARY	16,754	17-7	2
3	JAKOB BAKST	DIR OPERAT'NS	ADMIN/CONS.	32.02	SCHEDULES	5.4	9.06	" "	16,754	17-7	3
4	JAMEE O'BRIEN	REGIONAL DIR.	ADMIN	1.70	" "	5.4	9.06	" "	11,991	17-7	4
5	JOE ZIMMERMAN	CFO	CLERICAL	1.70	" "	5.4	9.06	" "	12,000	21-7	5
6	BARAK BAVER	OFFICE MANAGER	CLERICAL	0.56	" "	5.4	9.06	" "	6,551	21-7	6
7											7
8											8
9	HUNTER MGMT LLC -- ERIC ROTHNER		MGMT		" "			MGMT FEES	32,000	17-3	9
10											10
11											11
12											12
13								TOTAL	$ 96,050		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MANAGEMENT INC
Street Address: 5940 W TOUHY
City / State / Zip Code: NILES 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS	451,049	9 FACILITIES	$ 26,990	$ 26,990	51,221	$ 3,065	1
2	5	ELECTRICITY	" "	565,586	13 FACILITIES	7,834		51,221	709	2
3	6	REPAIRS	" "	565,586	13 FACILITIES	275		51,221	25	3
4	6	MAINTENANCE SALARIES	" "	565,586	13 FACILITIES	79,548	79,548	51,221	7,204	4
5	10	NURSING	" "	565,586	13 FACILITIES	301,295	301,295	51,221	27,286	5
6	10a	THERAPY SALARIES	" "	565,586	13 FACILITIES	39,798	39,798	51,221	3,604	6
7	17	ADMIN SALARIES	" "	565,586	13 FACILITIES	807,745	807,745	51,221	73,152	7
8	19	PROFESSIONAL FEES	" "	565,586	13 FACILITIES	44,637		51,221	4,042	8
9	20	DUES/LICENSES/WANT ADS	" "	565,586	13 FACILITIES	35,362		51,221	3,202	9
10	21	OFFICE SALARIES/EXPENSES	" "	565,586	13 FACILITIES	1,211,025	819,289	51,221	109,674	10
11	23	SEMINARS	" "	565,586	13 FACILITIES	14,490		51,221	1,312	11
12	24	TRAVEL	" "	565,586	13 FACILITIES	4,769		51,221	432	12
13	25	TRANSPORTATION	" "	565,586	13 FACILITIES	48,136		51,221	4,359	13
14	26	INSURANCE	" "	565,586	13 FACILITIES	30,286		51,221	2,743	14
15	27	EMPLOYEE BENEFITS	" "	565,586	13 FACILITIES	533,964		51,221	48,357	15
16	30	SL DEPRECIATION	" "	565,586	13 FACILITIES	116,219		51,221	10,525	16
17	32	INTEREST	" "	565,586	13 FACILITIES	333,416		51,221	30,195	17
18	34	OFFICE RENT	" "	565,586	13 FACILITIES	71,288		51,221	6,456	18
19	35	EQUIP RENT/AUTO LEASE	" "	565,586	13 FACILITIES	77,344		51,221	7,004	19
20	7	SECURITY	" "	565,586	13 FACILITIES	4,112		51,221	372	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,788,533	$ 2,074,665		$ 343,718	25

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY: RIVER PARK HEALTHCARE CENTER LLC						$	$			$	1
2	CIB BANK		X	CAPITAL IMPROVEMENTS	$1,390.84	01/04	58,543	46,459	1/09	PRIME+	3,215	2
3	LOAN COSTS		X	LOAN COSTS		02/01	1,350		W/O BAL		585	3
4	CAMBRIDGE		X	MORTGAGE	$29,195.15	11/03	5,141,900	5,072,634	10/33		281,342	4
5	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN	11/03	96,537	90,893			5,242	5
	Working Capital											
6	MIP INSURANCE		X	MORTGAGE INSURANCE							57,104	6
7	CAREPLUS MANAGEMENT ALLOCATION: LOC, ETC										30,195	7
8	INSURANCE FINANCING		X	INSUR. FINANCE							3,973	8
9	TOTAL Facility Related				$30,585.99		$ 5,298,330	$ 5,209,986			$ 381,656	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,298,330	$ 5,209,986			$ 381,656	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 57,104 Line # 32-7

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 134,710	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 135,986	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,276	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 137,350	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 138,626	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	120,444	8
	2000	122,973	9
	2001	128,360	10
	2002	133,374	11
	2003	135,986	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME RIVER PARK HEALTHCARE CENTER COUNTY ROCK ISLAND

FACILITY IDPH LICENSE NUMBER 0042549

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-341-78-00	NURSING HOME	$ 1,198.64	$ 1,198.64
2.	10-341-79-00	NURSING HOME	$ 134,787.32	$ 134,787.32
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 135,985.96	$ 135,985.96

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,494 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 4 + BASEMENT

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	RELATED PARTY:RIVER PARK HEALTHCARE CENTER LLC			$	1
2	NURSING HOME: 5.16 ACRES		1997	420,000	2
3	TOTALS			$ 420,000	3

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	RELATED PARTY: RIVER PARK HEALTHCARE CENTER LLC:				$	$		$	$	$	4
5	177		1997	1975	3,596,265	92,208	39	92,208		672,393	5
6											6
7											7
8											8
	Improvement Type**										
9	FLOORING,WALLCOVER,WINDOW TREATMENTS,DOORS			1997	66,202	1,698	39	1,698		12,971	9
10	WINDOWS			1998	2,278	58	39	58		377	10
11	WALK-IN FREEZER COMPRESSOR			2000	2,097	76	27.5	76		371	11
12	ELECTRICAL WORK			2001	1,854	67	27.5	67		249	12
13	NEW GREASE TRAP & CHANGEOUT WATER HEATER			2002	10,887	396	27.5	396		819	13
14	DOORS / CABLE INSTALLATION			2003	5,954	216	27.5	216		237	14
15	FIRE CODE REMODELLING			2004	38,126	916	27.5	916		916	15
16	KICKBOARDS			2004	9,240	182	27.5	182		182	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32	RELATED PARTY: CAREPLUS MANAGEMENT:					107		107			32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,732,903	$ 95,924		$ 95,924	$	$ 688,515	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 212,755	$ 18,146	$ 17,099	$ (1,047)	8-15 YRS	$ 91,546	71
72	Current Year Purchases	13,937	8,363	800	(7,563)	8-10 YRS	800	72
73	Fully Depreciated Assets							73
74	** REL'D PARTY-SL DEPN:CAREPL MGT,10,418/RIVER PARK LLC, 22,500		32,918	32,918				74
75	TOTALS	$ 226,692	$ 59,427	$ 50,817	$ (8,610)		$ 92,346	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY VAN		2001	$ 13,000	$ 1,498	$ 3,250	$ 1,752	4 YRS	$ 11,375	76
77										77
78										78
79										79
80	TOTALS			$ 13,000	$ 1,498	$ 3,250	$ 1,752		$ 11,375	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,392,595	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 156,849	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 149,991	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (6,858)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 792,236	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A -- RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 97,222 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$ 0	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 53,817	$		$ 53,817	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			21,011			21,011	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			88,138			88,138	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				128,436		128,436	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-2 / 39-3				23,645	37,007		60,652	12
13	MED.SUPPLIES/LAB/RENTALS Other (specify):	39-2					25,676		25,676	13
14	TOTAL			$		$ 186,611	$ 191,119		$ 377,730	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,800,192		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	626,740		5
6	Prepaid Insurance	39,642		6
7	Other Prepaid Expenses	29,010		7
8	Accounts Receivable (owners or related parties)	67,810		8
9	Other(specify): R.E,TAX ESCROW	15,751		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,579,145	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	49,153		15
16	Equipment, at Historical Cost	239,692		16
17	Accumulated Depreciation (book methods)	(206,797)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 82,048	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,661,193	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 985,804	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	123,772		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,742		31
32	Accrued Real Estate Taxes(Sch.IX-B)	137,350		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,260,678	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE TO LLC	144,731		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 144,731	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,405,409	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,255,784	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,661,193	$	48

***(See instructions.)**

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,819,967	1
2	Restatements (describe):		2
3	POST-CLOSING BAD DEBT ADJUSTMENT	(150,000)	3
4	POST-CLOSING EXPENSES & 2003 IL REPLACEMENT TAX	(20,669)	4
5	ROUNDING	(3)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,649,295	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	206,062	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,599,573)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,393,511)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,255,784	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,839,203	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,839,203	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	334	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 334	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	142,447	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 142,447	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,981,984	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	922,156	31
32	Health Care	2,235,439	32
33	General Administration	1,427,927	33
	B. Capital Expense		
34	Ownership	715,496	34
	C. Ancillary Expense		
35	Special Cost Centers	377,730	35
36	Provider Participation Fee	97,174	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,775,922	40
41	**Income before Income Taxes (line 30 minus line 40)****	206,062	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 206,062	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,696	4,187	$ 107,985	$ 25.79	1
2	Assistant Director of Nursing	2,004	2,094	42,131	20.12	2
3	Registered Nurses	4,874	5,203	98,658	18.96	3
4	Licensed Practical Nurses	34,310	36,904	580,876	15.74	4
5	Nurse Aides & Orderlies	64,153	65,446	649,224	9.92	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	403	434	8,477	19.53	7
8	Rehab/Therapy Aides	9,360	10,039	107,921	10.75	8
9	Activity Director	1,965	2,183	24,447	11.20	9
10	Activity Assistants	5,809	6,350	57,277	9.02	10
11	Social Service Workers	4,449	4,916	77,370	15.74	11
12	Dietician					12
13	Food Service Supervisor	2,032	2,169	34,923	16.10	13
14	Head Cook	7,360	7,928	61,680	7.78	14
15	Cook Helpers/Assistants	10,612	10,902	71,628	6.57	15
16	Dishwashers					16
17	Maintenance Workers	3,972	4,208	50,862	12.09	17
18	Housekeepers	16,575	17,574	137,808	7.84	18
19	Laundry	8,221	8,718	64,950	7.45	19
20	Administrator	2,028	2,265	75,361	33.27	20
21	Assistant Administrator	1,742	1,783	34,303	19.24	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,226	6,677	90,338	13.53	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,814	2,007	19,229	9.58	31
32	Other Health Care(specify)					32
33	Other(specify) MARKETING	1,212	1,290	17,809	13.81	33
34	TOTAL (lines 1 - 33)	192,817	203,277	$ 2,413,257 *	$ 11.87	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 13,322	1-3	35
36	Medical Director	O	16,800	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	400	10-3	39
40	Physical Therapy Consultant	L	7,200	10a-3	40
41	Occupational Therapy Consultant	Y	7,200	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	59	11-3	44
45	Social Service Consultant	E	2,115	12-3	45
46	Other(specify)	S			46
47	PSYCHIATRIC		50,000	10-3	47
48	PA & M/C CONSULTANT		225,000	10-3	48
49	TOTAL (lines 35 - 48)		$ 322,096		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0		50
51	Licensed Practical Nurses		0		51
52	Nurse Aides		0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CHRIS WELCH	ADMIN	0	$ 75,361
DAWN MAY	ASST ADMIN	0	34,303
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 109,664

B. Administrative - Other

Description		Amount
CAREPLUS MGMT	MANAGEMENT FEES	$ 126,000
HUNTER MGMT	MANAGEMENT FEES	32,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 158,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		353,712
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 353,712

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 64,383
Unemployment Compensation Insurance		34,475
FICA Taxes		181,183
Employee Health Insurance		46,120
Employee Meals		13,725
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		3,470
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 343,356

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,444
Health Care Worker Background Check	108
(Indicate # of checks performed 9)	
MARKETING/ADV/PROMO	9,254
TRUST/FRANCHISE/CONTRIB/ETC	485
LICENSES & PERMITS	1,283
DUES & SUBSCRIPTIONS	122
MGMT CO ALLOCATION	3,202
TRUST/FRANCHISE/CONTRIB/ETC	(485)
Less: Public Relations Expense	(0)
Non-allowable advertising	(8,769)
Yellow page advertising	(485)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,159

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL & LODGING	1,395
MGMT CO ALLOCATION	432
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,827

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINT/DECORATING	2001	$ 2,062	3	$ 344	$ 687	$ 687	$ 344	$	$	$	$	$
2	PAINT/DECORATING	2002	6,681	3		1,114	2,227	2,227	1,113				
3	PAINT/DECORATING	2003	2,529	3			422	843	843	421			
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 11,272		$ 344	$ 1,801	$ 3,336	$ 3,414	$ 1,956	$ 421	$	$	$

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,310** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **97,174**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **13,725** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees